ETCH
EARLY TREATMENT
& COGNITIVE HEALTH

CONSENT FOR TREATMENT

CONFIDENTIALITY: All information from our sessions and the records we must keep about these sessions are confidential and may not be revealed to anyone without your permission except when required by law. We have given you a copy of the Notice of Privacy Practices, which described all of our policies.

HEALTH INSURANCE AND CONFIDENTIALITY OF RECORDS: Sometimes your insurance carrier may require us to provide them with information about your treatment before they will pay the claim. In these situations, we will give them only the minimum necessary information. ETCH, LLC has no control over or knowledge of what the insurance company does with the information we provide.

WHEN DISCLOSURE IS REQUIRED BE LAW: We are required to take action and notify the appropriate people if we feel that you are being abused, neglected or in danger of harming yourself or others.

EMERGENCIES: If there is an emergency, I will do whatever I can, within the limits of the law, to prevent you from hurting yourself or others and to ensure that you get proper care. This will occur if I become concerned about your personal safety, the possibility of you injuring someone else, or about you receiving proper psychiatric care. In this event, I will also contact the person whom you have agreed that I can contact. I will also share information, in the event of an emergency, with hospitals and/or emergency personnel.

TELEPHONE AND EMERGENCY PROCEDURES: If you need to reach me between sessions, you may leave a message for me at (517) 481-4800. I will return your call as soon as possible. We are not able to respond to life-threatening emergencies; in these situations, please call your physician, or proceed to your nearest emergency room. I will notify you in advance if I am going to be away from work.

PAYMENTS AND INSURANCE: Clients assume total responsibility for professional fees generated in the course of treatment or evaluation. In the case of a dependent in therapy, the parent/guardian assumes full responsibility for professional fees. Fees are due in full, in the session directly following receipt of a bill. We will bill the insurance company based on the information you have provided us. Those clients who are utilizing their insurance must keep themselves informed regarding the limitations of their insurance and make arrangements for payment with their therapist. If you have Medicare they will usually pay 50% of the cost. Secondary insurance plans may pay the remaining 50%, or a portion of this balance. You will be responsible for any part of the cost not reimbursed by your insurance. Also, please note that copays are due at the time of service.

In order to submit a claim for payment to us for services covered under your policy, we must have authorization to release medical information to our billing company for paper & electronic billing and your insurance company.

I authorize the release of any medical information necessary to process my medical service claims. I permit a copy of this authorization to be used in place of

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the original. I hereby authorized ETCH's billing company to file for benefits on my behalf for medical services rendered. Insurance payments shall be made directly to therapist. If I have Medicare insurance, I authorize the therapist to release to the Social Security and Care Financing Administration or its intermediaries or carriers any information needed for this or a related Medicare claim. I certify that I am financially responsible for all services not paid by insurance. This authorization is valid indefinitely until revoked by myself or by the therapist by written request.

ASSIGNMENT: I hereby instruct and direct my insurance company to pay ETCH, LLC directly for professional expenses allowable and otherwise payable to me under my current insurance policy, as payment toward the total charges for professional services rendered by this agency. A photocopy of the assignment shall be considered as effective and valid as the original.

TREATMENT PLAN: Within two weeks of the start of treatment, I will discuss with you the goals that you have for counseling and ways that we can work together to help you reach these goals. We will review your progress on a regular basis.

CANCELLATIONS: If you must cancel and reschedule an appointment, we ask that you notify your therapist at least 24 hours in advance of your session. *There may be a fee for appointments missed without a 24-hour notice of cancellation*.

I HAVE READ THE ABOVE AGREEMENT, UNDERSTAND THE POLICIES, AND CONSENT TO TREATMENT.

_____ _____

Client or Parent/Guardian Printed Name | Signature | Date

_____ _____

Clinical Staff Printed Name | Signature | Date

I HAVE RECEIVED THE "NOTICE OF PRIVACY PRACTICES" FROM AN ASSOCIATE OF ETCH, LLC.

_____

Client Signature | Date